# 2003
# Basic Health Member Handbook

HCA 22-405 (1/03)

# Health Plan Phone Numbers and Web Sites

| | Customer Service Hours: | Customer Service Phone Numbers: | Web Site Address: |
|---|---|---|---|
| **Assuris Northwest Health** | Mon. – Fri.<br>7:30 a.m. – 5 p.m. | 1-866-240-9580<br>TTY: 253-573-3260 | www.asurisnorthwesthealth.com |
| **Columbia United Providers, Inc.** | Mon. – Fri.<br>8 a.m. – 5 p.m. | 1-800-315-7862 or<br>360-891-1520<br>TDD: 1-866-287-9962 | |
| **Community Health Plan of Washington** | Mon. – Fri.<br>8 a.m. – 6 p.m. | 1-800-440-1561<br>TTY: 1-800-833-6388 | www.chpw.org |
| **Group Health Cooperative of Puget Sound** | Mon. – Fri.<br>8 a.m. – 5 p.m. | 1-888-901-4636<br>TTY: 1-800-833-6388 | www.ghc.org |
| **Kaiser Foundation Health Plan of the Northwest** | Mon. – Fri.<br>8 a.m. – 7 p.m. | 1-800-813-2000<br>TTY: 1-800-324-8007 | www.kp.org |
| **Molina Healthcare of Washington, Inc.** | Mon. – Fri.<br>7:30 a.m. – 6 p.m. | 1-800-869-7165<br>TTY: 1-877-665-4629 | www.molinahealthcare.com |
| **Premera Blue Cross** | Mon. – Fri.<br>8 a.m. – 5 p.m. | 1-800-691-3072<br>TTY: 1-800-842-5357 | www.premera.com |
| **Regence BlueShield** | Mon. – Fri.<br>7:30 a.m. – 5 p.m. | 1-800-560-5731<br>TTY: 253-573-3260 | www.wa.regence.com |

## Washington "Hotline" Phone Numbers

Alcohol and Substance Abuse ..... 1-800-562-1240

Domestic Violence ..... 1-800-562-6025

Emergency Contraceptive Advice ..... 1-888-NOT-2-LATE (1-888-668-2528)

Family Planning ..... 1-800-770-4334

HIV/AIDS (National) ..... 1-800-342-AIDS (1-800-342-2437)

Poison Control ..... 1-800-732-6985

| If you have any questions about… | Call… |
|---|---|
| • **Adding and/or dropping a family member**<br>• **Address changes**<br>• **Income changes** | Basic Health toll-free at:<br>1-800-842-7712 to request forms or to hear recorded information;<br>1-800-660-9840 to talk to a Basic Health benefits specialist, or<br>go to www.basichealth.hca.wa.gov. |
| • **Bills received for services**<br>• **Choosing a primary care provider**<br>• **Covered services**<br>• **Services received from providers**<br>• **Waiting periods** | Your health plan. (See the phone number on the inside cover of this handbook.) |
| • **Your medical care**<br>• **Referrals to specialists** | Your primary care provider. |
| • **Premium amount**<br>• **Premium payments**<br>• **Billing statements**<br>• **Refunds** | Basic Health toll-free at:<br>1-800-842-7712 for 24-hour, self-service verification of premium payment information; or<br>1-800-660-9840, then follow the recorded instructions to speak with an accounting representative. |

# When you call or write us…

Be sure to include your **name, subscriber I.D. number, address,** and a **daytime phone number.**

If you speak with a representative, it is helpful if you note the date of the call, the name of the person you talked to, and whether the representative was with Basic Health or your health plan. If you are enrolled as part of an employer group, home care agency, or financial sponsor group, first contact your group representative (usually your payroll officer or financial sponsor representative). He or she may have the information you need, or may need to know about a change you're reporting.

To obtain this document in another format (such as Braille or audio), call our Americans with Disabilities Act (ADA) Coordinator at 360-923-2805. TTY users (deaf, hard of hearing, or speech impaired), call 360-923-2701 or toll-free 1-888-923-5622.

Si desea ayuda en español, llame al 1-800-321-0291. Для обслуживания на русском языке, позвоните, пожалуйста, по телефону 1-800-387-8224.
한국어로 도움을 원하시면 1-800-324-1658로 연락하십시오. Nếu quý vị muốn được giúp bằng tiếng Việt, xin gọi số 1-800-423-2231.

# At a Glance

**Basic Health office hours** ..... Monday through Friday, 7:30 a.m. until 5:30 p.m.

**Mailing addresses**

Premium payments (with payment stub only) ..... P.O. Box 34270, Seattle, WA 98124-1270

General correspondence ..... P.O. Box 42683, Olympia, WA 98504-2683

Basic Health appeals (see pages 19-20) ..... P.O. Box 42690, Olympia, WA 98504-2690

**Basic Health Web site** ..... www.basichealth.hca.wa.gov
(Includes provider directory, *How Much Will Basic Health Coverage Cost?*, and other useful information)

**Family additions (report new family members even if not enrolling them)**

| ***If you are adding (a):*** | ***Application form must be received by Basic Health:*** |
|---|---|
| Newborn | Within 60 days of birth |
| Newly adopted child | Within 60 days of placement for adoption |
| Other child | Within 30 days of marriage or custody change |
| New spouse | Within 30 days of marriage |
| Yourself or an eligible family member due to loss of other coverage | Within 30 days of loss |

You may add family members for family size information only, at any time

**If you are pregnant ..... Notify Basic Health immediately (see pages 15–16)**

**Other account changes**

Income change: You must notify Basic Health of a change that affects your income, such as a job change, a change in the number of hours worked, a marriage, or divorce. **You are required to report an income change no more than 30 days after the end of the first month at the new income level.** See important information on page 9).

Address change ..... Use the *Change Form* included with your monthly billing statement

Premium due date ..... 5th of each month (pays for the following month of coverage)

# Table of Contents

# Chapter One: Introduction

## What is Basic Health?

Basic Health offers quality, affordable health coverage to eligible Washington State residents. Basic Health is a state program administered by the Washington State Health Care Authority (HCA). The HCA contracts with health plans to offer Basic Health and Basic Health *Plus* to eligible Washington State residents. Each health plan, in turn, contracts with hospitals, clinics, pharmacies, physicians, and other providers to form that health plan's network of providers who deliver health services to Basic Health and Basic Health *Plus* members. For some Basic Health *Plus* and Maternity Benefits Program services, such as dental and vision care, the state pays the provider directly.

As a Basic Health member, your monthly premiums are based on your (and your dependents') age, family size, income, and the health plan you choose. The amount of your premium is only a portion of the total payment that is paid to the health plan for your coverage. The greater part of the premium paid for your coverage is subsidized by the state. If your income increases, you may pay a higher percentage of your premium and, in some cases, you may be disenrolled. For more information on income guidelines, refer to *How Much Will Basic Health Coverage Cost?* on our Web site or call 1-800-660-9840.

You must follow your health plan's guidelines and procedures to receive the benefits described in this handbook. You may also be required to provide your health plan or Basic Health with information (including medical records) needed to determine eligibility for benefits or to process claims. Guidelines and procedures may vary from health plan to health plan. Be sure to read your health plan's materials for details and call your health plan first if you have any questions about benefits.

## How do I use this handbook?

This handbook serves as your certificate of coverage. It describes the services and supplies covered by Basic Health, and the rules you must follow when using this coverage. This handbook is subject to the administrative rules of Basic Health, chapter 182-25 of the Washington Administrative Code (WAC), as amended.

Keep your *Member Handbook* in a convenient place and refer to it whenever you have a question about your benefits. We've provided some handy resources, including forms for reporting income changes and a list of phone numbers in case you have questions not answered here.

Basic Health sometimes sends publications such as *Hot Policy Pages*, open enrollment information, or other notices to keep you informed and notify you of changes. These may include amendments to the information in this handbook. You should keep these publications with your *Member Handbook* for future reference.

This handbook also contains additional information for members of Basic Health for Groups at the end of many sections. Information specifically for members enrolled in the Maternity Benefits Program and Basic Health *Plus* is contained in a separate document. If any member(s) of your family are enrolled in Basic Health *Plus* and/or the Maternity Benefits Program, you should have received a separate document with information about this program. If you did not receive this document, or would like to request a copy, please contact Basic Health at 1-800-660-9840 and one will be sent to you.

Throughout this handbook, "you" generally refers to the main subscriber on your Basic Health account or to an adult who will be reading and referring to coverage information on behalf of a child.

# Chapter Two: How Does Basic Health Work?

## Who is eligible for Basic Health coverage?

Basic Health is available to any Washington resident who:

- **Meets income guidelines;**
- **Is not eligible for Medicare; and**
- **Is not institutionalized (at the time of enrollment) in a government-funded facility that has historically provided health care.**

You are considered "eligible" for Medicare if you are eligible for free or **purchased** Medicare coverage.

Family members who should be listed as dependents on your account include your:

- **Spouse living in the same household and not legally separated.**
- **Unmarried children, including stepchildren, legally adopted children, and children placed in your home for purposes of adoption or under your legal guardianship; who are:**
  - Under age 19; or
  - Under age 23, if full-time student(s) at an accredited school. You are required to send verification from the school each year when your dependent is age 19 through 22, to show that he or she is a full-time student. You must notify Basic Health within 30 days when your dependent over age 19 is no longer a full-time student.
- **Your child, stepchild, or legal dependent of any age, who is not capable of self-support due to disability. You may be required to provide documentation of your child's or stepchild's disability, and must provide documentation of legal guardianship for a disabled dependent who is not your child or stepchild.**
- **An unmarried child under age 19 who is living with you under an informal guardianship agreement and who is enrolled or enrolling for coverage on your account. You will be required to provide a copy of the agreement signed by the parent, authorizing you to provide medical care for the child (this may be specific to medical care or may be authorization to provide all care and/or make all major decisions regarding the child). You must also include verification that you are providing at least 50 percent of the child's support.**

Family members who are not eligible for coverage on your account may be eligible to enroll separately — for example, a child who reaches age 19 and is not disabled or attending school full time. To apply for Basic Health coverage, this child must complete a separate application and apply under his/her own account.

### Basic Health *Plus*

Basic Health *Plus* is a Medicaid program for children under age 19. It's run by Basic Health and the Department of Social and Health Services' Medical Assistance Administration, which will be referred to as "DSHS" throughout the rest of this handbook. With Basic Health *Plus*, eligible children receive additional health care coverage such as dental care, vision care, and physical therapy. Medicaid pays the entire cost for Basic Health *Plus* coverage, including monthly premiums and copayments. Children enrolled in Basic Health *Plus* will receive services through the same health plan that provides your Basic Health coverage.

Your children may be eligible for Basic Health *Plus* if you meet Basic Health income guidelines. To be eligible, the children must be your legal dependents, live in your home, and be:

- **Under age 19;**
- **U.S. citizens, or immigrants who arrived in the U.S. on or before August 22, 1996;**

- **Not enrolled in any other managed care plan, including TRICARE; and**
- **Not receiving Temporary Assistance for Needy Families (TANF) grants from DSHS.**
  If you would like to transfer your child's coverage from Basic Health to Basic Health *Plus*, call 1-800-842-7712 or visit our Web site for a Basic Health *Plus* application.

### Basic Health for Groups

In addition to individual coverage, Basic Health is available to groups. Employers, home care agencies, and financial sponsors may enroll their employees or sponsored members in a Basic Health group account. If you are covered through a group account, your employer or financial sponsor pays your premium, but may collect part of it from you. Under group membership, your main contact with Basic Health will be through your group representative.

If your employer, home care agency, or financial sponsor doesn't pay the premium on time, you may be disenrolled from Basic Health group coverage. If your group is disenrolled, Basic Health will offer you coverage under an individual account, but you may have a period of time without coverage.

### Basic Health for foster parents and personal care workers

If you are currently licensed by DSHS as a foster parent or under contract with DSHS as a personal care worker, and your income qualifies you for a reduced premium, you may be able to pay an even lower premium for Basic Health coverage.
For further information or to request a foster parent or personal care worker application packet, call 1-800-660-9840 or check Basic Health's Web site. To apply for this lower premium, complete the *Certification Form* in the packet and return it to Basic Health, along with the requested documentation.

## How the health plans work

All the health plans offer the same basic benefit package and require you to choose a primary care provider (PCP) to coordinate or provide your care. However, costs, providers and facilities, covered prescription drugs, referral practices, and other guidelines may differ by health plan.

Each health plan contracts with a number of providers and facilities (called the health plan's "provider network"). Your health plan may refer you to a specialist or facility outside the health plan's network if you or your child needs a provider or hospital not available in your health plan's network. You must get your health plan's approval to be treated by a provider or facility not available through your health plan's provider network, except in an emergency (see page 15).

Some health plans may contract with provider groups called subnetworks; **this may restrict your choice of providers.** You may be required to see specialists or use facilities, such as hospitals, which are in the same subnetwork as your PCP. This means that, even if a provider is affiliated with your health plan, the provider's services may not be available to you unless the provider is also affiliated with your PCP.

Call the health plan or your PCP to find out if your PCP can refer you to anyone listed as a provider with that health plan, or if your PCP can refer you to only a selected group of providers within the health plan.

### Your primary care provider

Each covered family member must enroll in the same health plan, but may choose a different primary care provider (PCP) within that health plan. Except in an emergency, your PCP and staff will provide or coordinate all of your health care needs, including referrals to specialists. Primary care providers may be family or general practitioners, internists, pediatricians, or other providers approved by your health plan. You may

change your PCP during the year. Contact your health plan for details on changing providers or for a current list of providers. You may also contact the provider you're considering and ask if he or she contracts with your health plan for Basic Health coverage. When you call a provider, be sure to mention the health plan name and Basic Health, and ask whether the provider participates in the health plan.

To be covered by your health plan, your PCP must provide all health care services, unless:

- **You are referred by your primary care provider (in most cases, the referral must be approved by your health plan); or**
- **You need emergency care, as described on page 15; or**
- **You self-refer for women's health care services or covered chiropractic care to a provider who contracts with your health plan.**

If you have questions, call your health plan at the number listed on the inside cover of this handbook.

### Dependent temporarily out of county/state

If your dependent child is temporarily away at school (or lives away from you part of the time), he or she may still be covered under Basic Health as long as he or she maintains Washington State residency. If possible, select a health plan that provides service to both your home county and the county in which your child is located. Basic Health will cover only emergency care while your child is out of state or staying in a county that is not served by your health plan. Any routine services for that child should be scheduled for a time when he or she is home. When necessary, Basic Health allows your dependents to enroll in a different health plan under a separate account so that your dependent may receive services within the county where he or she lives. There will be a separate billing for that account.

## Women's health care services

Members may access the following women's health care services without a PCP referral or health plan preauthorization. **You may seek these services from any women's health care provider who contracts with your health plan.** Facility services such as those provided by hospitals or outpatient surgical centers may require preauthorization from your health plan. The following women's health care services are covered under this benefit:

- Maternity care, including prenatal, delivery, and postnatal care.
- Routine gynecological exams.
- Except as specifically excluded, examination and treatment of disorders of the female reproductive system.
- Other health problems discovered and treated during the course of a woman's health care visit, as long as the treatment is within the provider's scope of practice, and the service provided is not excluded.

Any follow-up services for conditions not directly related to maternity care, routine gynecological exams, or disorders of the female reproductive system and **services such as those provided by hospitals or outpatient surgical centers** may require referral and preauthorization by your health plan.

## Identification cards

After your enrollment in Basic Health, the health plan will send identification (I.D.) cards for you and your enrolled family members. Some health plans may require that you choose a PCP before they will issue your I.D. card. The card has important information, including the number to call if you are hospitalized or have questions. If you need care before you receive the card, contact the health plan at the number listed on the inside

cover of this handbook. Your enrollment confirmation letter from Basic Health can serve as temporary identification before you receive your card.

## When will my coverage begin?

Basic Health will notify you in writing when your Basic Health or Basic Health *Plus* coverage is effective. It generally takes four to six weeks to process your application once all information is received. Basic Health may enroll only a limited number of people in the reduced-premium program. If we reach that limit, Basic Health will delay your coverage until space is available. **Please note:** Even if your payment has been processed, your coverage will not begin until after your application has been approved and space is available.

## When will coverage begin for family members being added to my account?

If you marry and you follow the procedures explained in "Family Changes," coverage for your new spouse and stepchildren, if any, will begin on the first day of the month after eligibility has been determined.

Your newborn or adopted child is covered from the date of birth or placement in your home if you or a family member are enrolled in Basic Health or Basic Health *Plus*, only if Basic Health receives your application to enroll the child within 60 days of the birth or placement. If Basic Health receives your application to add your new child more than 60 days after the child's birth or placement, your child will be added for family size only and will not have medical coverage. Refer to page 11 for instructions on applying for coverage for a new family member.

If you want to stop Basic Health coverage, refer to page 13 for instructions on how to disenroll.

## Premium payments

Your premiums are due no later than the fifth day of the month prior to the actual month of coverage; the amount and due date are shown on each month's billing statement. You are sent a statement for coverage approximately six weeks before the month covered by that payment. For example, your statement for August coverage is sent mid-June and your premium is due July 5.

If you do not pay the entire premium on time, your statement for the next month will include a delinquency notice. Your payment for the total amount shown must be received by Basic Health by the due date given on the notice, or your coverage will be suspended for one month. Partial payment, or checks returned for non-sufficient funds or missing a signature, will be considered nonpayment and may also cause you to be suspended or disenrolled. For more information on suspension or disenrollment, refer to page 13.

## Recertification

State law requires Basic Health to periodically verify that our members' income and eligibility information is up to date. Under this "recertification" process, Basic Health subscribers receive a letter requesting recertification information to show the amount of their current income and other relevant documentation. Being selected for recertification does not mean that Basic Health believes you have given us the wrong information; it is a legal requirement.

If you receive a recertification request letter, you must send Basic Health all the documentation requested by the due date given. If you do not send all information requested, you and your family will be disenrolled and you may not re-enroll for at least 12 months. If you reapply for Basic Health at the end of the 12 months, you will be required to provide complete documentation of income and eligibility with your application, and your enrollment may be delayed until space is available.

## Recoupment

You must notify Basic Health right away of a change that affects your income such as a job change, a change in the number of hours worked, a marriage, or divorce. Basic Health may also verify the amount of your income through contact with other state or federal agencies. If it appears that you have not reported an income increase to Basic Health that would affect your premium, Basic Health will send you a "Notice of Income Verification," informing you of this. If you believe you do not owe the amount shown on that notice, you must provide the documentation requested by the due date given. If you do not respond, or if you are unable to prove that the amount of income you reported to us was correct, Basic Health will bill you for the full amount the state overpaid for your coverage (called "recoupment"). If we find that your premiums were calculated incorrectly because you intentionally provided misleading or fraudulent information or withheld information you knew or should have known was necessary to calculate your premium correctly, Basic Health may bill you up to twice the amount due. In cases of fraud, Basic Health may take additional legal action, such as prosecution for perjury and disenrollment back to the date of the fraud.

If you are billed for recoupment (repayment of the state subsidy overpayment), you may be disenrolled unless you pay the amount due, according to the billing schedule established by Basic Health. If you are disenrolled under these circumstances, you will not be allowed to re-enroll for at least 12 months and until your account balance is paid. If it becomes necessary to refer your account to a collection agency for collection of the amount due, you will be responsible for any fees or charges associated with the collection proceedings, as well as the full balance due on your account.

## Rights and responsibilities

**As a Basic Health member, you and your enrolled dependents have the right to:**

- Understand Basic Health.
- Get readable, understandable notices or have the materials explained or interpreted.
- Receive timely information about your health plan.
- Get courteous, prompt answers from your health plan and Basic Health.
- Be treated with respect, dignity, and a right to privacy by your health plan and its providers.
- Obtain information about all medical services covered by Basic Health.
- Choose your health plan and primary care provider from among available health plans and their contracted networks.
- Receive proper medical care without discrimination no matter what your health status or condition, sex, ethnicity, race, marital status, or religion, consistent with Appendix A of this handbook.
- Get all medically necessary covered services and supplies listed in the Basic Health Schedule of Benefits, subject to the limits, exclusions, and copayments described in Appendix A.
- Participate in decisions about your and your child's health care, including having a candid discussion of appropriate or medically necessary treatment options, regardless of cost or coverage.
- Get medical care without a long delay.
- Refuse treatment and be told of the possible results of refusing.

- Expect your and your child's records or conversations with providers to be kept confidential.
- Obtain a second opinion by another health plan provider when you disagree with the initial provider's recommended treatment plan.
- Make a complaint about the health plan or providers and receive a timely answer.
- File an appeal with your health plan or Basic Health if you are dissatisfied with a decision (please refer to pages 19–20).
- Receive a review of a Basic Health appeal decision, if you disagree with it.
- Change your primary care provider for a good reason (call your health plan for assistance).

**As a Basic Health member, you and/or your dependent have the responsibility to:**

- Accurately, and promptly report changes of address, family status, or income when they happen and submit required forms and documentation.
- Select one of the health plans available in your area.
- Select a primary care provider from your health plan before receiving services.
- Cooperate with your health plan to help obtain any third-party payments for medical care.
- Report to your health plan any outside sources of health care coverage or payment, such as insurance coverage for an accident.
- Inform your or your child's primary care provider of medical problems and ask questions about things you do not understand.
- Decide whether to receive a treatment, procedure, or service.
- Get medical services from (or coordinated by) your or your child's primary care provider, except in an emergency or in the case of a referral.
- Get a referral from the primary care provider before you go, or take your child, to a specialist.
- Pay Basic Health copayments in full at the time of service.
- Pay your Basic Health premiums in full by the date they are due.
- Not engage in fraud or abuse in dealing with Basic Health, Basic Health *Plus*, your health plan, your primary care provider, or other providers.
- Keep appointments and be on time, or call the provider's office when you or your child will be late or can't keep the appointment.
- Keep your medical I.D. card with you or your child at all times.
- Notify the health plan or primary care provider within 24 hours or as soon as is reasonably possible of any emergency if services have been provided outside the health plan.
- Use only your selected health plan and primary care provider to coordinate services for your family's medical needs.
- Comply with requests for information, such as previous medical records or other coverage, by the date requested.
- Submit updated proof of eligibility if there is a change in your income.
- Cooperate with your primary care provider and referred providers by following recommended procedures or treatment.
- Work with your health plan and providers to learn how to stay healthy.

## Informed Consent

**You have the right to give your consent to treatment or care.** You have the right to know about the possible side affects of your care and give your consent before you get care. Be sure to ask your provider about the side affects of your care.

## Advance Directives

Advance Directives put your choices into writing. They may also name someone to speak for you if you are not able to speak. Before signing such a document, you should talk to a lawyer or legal counselor. Washington State law has two kinds of Advance Directives:

1. **Durable Power of Attorney for Health Care** – This names another person to make medical decisions for you if you are not able to make them for yourself.
2. **A Directive to Physicians (Living Will)** – A statement that you want to die naturally and don't wish to have treatments that will prolong your life.

## Personal Health Information

The Health Care Authority will not release any personal health information that is provided either verbally, electronically or in writing to anyone but you or your health plan without your prior written authorization.

## Account privacy

Without your written authorization, the Health Care Authority cannot release personal account details such as eligibility, enrollment, monthly premium, or payment to anyone but you or your health plan.

**Exceptions:**

- If your employer, a home care agency, or a financial sponsor is paying your premium, limited information may be released to your group representative. Ask your group representative for details.
- Information about a non-emancipated minor child will be released to either parent.
- Your information may be shared with DSHS if DSHS is paying all or part of your premium (for example, if you are applying for or enrolling in Basic Health *Plus* or the Maternity Benefits Program, or as a foster parent, personal care worker, or home care worker).

If you want to let someone else such as a friend or a relative access or make changes to your account details, you need to send written authorization to Basic Health. Be sure to sign and date your letter and include the person's name, their relationship to you, and what information you want released to them or changes they can make. Only the information you specify will be released. You will also need to specify if this permission is being granted for a specific time period or for as long as you remain enrolled in Basic Health. When this person calls, they'll need your Basic Health subscriber I.D. number, and will be asked for other identifying information.

# Chapter Three:
# Making Changes to Your Account

To make some types of account changes or to request forms, use the detachable *Change Form* included with your billing statement. We have included a copy of the form for reporting income changes in the back of this handbook. To request additional forms call our 24-hour, automated, self-service phone line, 1-800-842-7712 or visit our Web site. You may also write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683.

## Income changes

If your income or family size changes, your monthly premium may change, too. If your family income changes (for example, your job or the number of hours you work changes, you get married or divorced or you begin to receive income from a new source), you are required to report the income change to Basic Health within 30 days of the end of the first month at the new income level. Be sure to also notify Basic Health if your income decreases. After your income changes you must continue paying your premium as billed until we notify you of the new premium amount. (See additional information under "Recertification" on page 5 and "Recoupment" on page 6.)

If you begin receiving social security disability benefits, whether or not your income changes, you must promptly notify Basic Health. This may affect your eligibility for Basic Health. Please also refer to the following list when sending income information to Basic Health. (If this information changes, you will be notified. Be sure to read updates you receive and keep them with this handbook.)

***Include* all income received from the following sources (or any combination of these sources), or money received from any other source:**

- Salaries, wages, commissions, tips, and work study income
- Self-employment and rental income
- Unemployment income and strike benefits

| Family Size | | | | | | | Income Bands |
|---|---|---|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 | 6 | 7 | |
| $0 – $479.91 | $0 – $646.74 | $0 – $813.58 | $0 – $980.41 | $0 – $1,147.24 | $0 – $1,314.08 | $0 – $1,480.91 | A |
| 479.92 – 738.33 | 646.75 – 994.99 | 813.59 – 1,251.66 | 980.42 – 1,508.33 | 1,147.25 – 1,764.99 | 1,314.09 – 2,021.66 | 1,480.92 – 2,278.33 | B |
| 738.34 – 922.91 | 995.00 – 1,243.74 | 1,251.67 – 1,564.58 | 1,508.34 – 1,885.41 | 1,765.00 – 2,206.24 | 2,021.67 – 2,527.08 | 2,278.34 – 2,847.91 | C |
| 922.92 – 1,033.66 | 1,243.75 – 1,392.99 | 1,564.59 – 1,752.33 | 1,885.42 – 2,111.66 | 2,206.25 – 2,470.99 | 2,527.09 – 2,830.33 | 2,847.92 – 3,189.66 | D |
| 1,033.67 – 1,144.41 | 1,393.00 – 1,542.24 | 1,752.34 – 1,940.08 | 2,111.67 – 2,337.91 | 2,471.00 – 2,735.74 | 2,830.34 – 3,133.58 | 3,189.67 – 3,531.41 | E |
| 1,144.42 – 1,255.16 | 1,542.25 – 1,691.49 | 1,940.09 – 2,127.83 | 2,337.92 – 2,564.16 | 2,735.75 – 3,000.49 | 3,133.59 – 3,436.83 | 3,531.42 – 3,873.16 | F |
| 1,255.17 – 1,365.91 | 1,691.50 – 1,840.74 | 2,127.84 – 2,315.58 | 2,564.17 – 2,790.41 | 3,000.50 – 3,265.24 | 3,436.84 – 3,740.08 | 3,873.17 – 4,214.91 | G |
| 1,365.92 – 1,476.74 | 1,840.75 – 1,990.09 | 2,315.59 – 2,503.45 | 2,790.42 – 3,016.81 | 3,265.25 – 3,530.17 | 3,740.09 – 4,043.53 | 4,214.92 – 4,556.89 | H |

- Social Security benefits and Supplemental Security Income
- Retirement and pensions
- Child support, family support, and alimony
- Insurance benefits, income from interest, including interest on IRA distributions, dividends, trusts, annuities, and royalties
- Veterans' benefits and military allotments
- Labor and Industries benefits
- Public assistance (DSHS cash assistance)
- Estate income, gambling/lottery winnings
- All other income that's not specifically in the "Income does not include" list

**Income does *not* include:**

- Income, such as wages, earned by dependent children
- Capital gains
- Any assets drawn down as withdrawals from a bank, or proceeds from the sale of property, such as a house or car
- Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for any injury (except workers' compensation)
- Income from a family member who lives in another household, when that income is not available to you or eligible dependents seeking Basic Health enrollment
- University scholarships, grants, fellowships, or assistantships
- Non-cash benefits (such as food stamps, school lunches, or housing assistance)
- Payments for adoption support received from the Department of Social and Health Services

***Reporting income changes.*** Please send the *Monthly Income Worksheet* (included in the back of this handbook), along with:

- Copies of your family's pay stubs and proof of gross income (before taxes) from all sources for the entire month or last 30 days; and
- A copy of your federal income tax return for the most recent tax year. This needs to include your IRS Form 1040 and all schedules you filed, and your form K-1 if applicable (we are unable to use your form W-2 or e-file transmittal sheet). Regardless of whether you filed by mail or electronically, you must sign your federal income tax return. Your tax preparer's signature is not sufficient. If you were not required to file or do not have a copy of your tax return for the most recent reporting year, contact the IRS by calling 1-800-829-1040 and request a "Return for Taxpayer" (RTFTP) or Verification of Nonfiling Status. These are available to you at no cost.
- A *Self-Employment/Rental Income Worksheet*, if required. For additional information or to see if you need to send this form, read the instructions with the worksheet in the back of this handbook.

Basic Health will notify you of how your change in income may affect your monthly premium or eligibility. This notice, called a "personal eligibility statement," may explain that you have an additional premium due.

**How we determine your income**

Unless the current income documentation you send shows that your circumstances have changed since you filed your tax return, Basic Health will use an average of your income as reported to the IRS to determine your premium responsibility. However, if your current income documentation shows your circumstances have changed, Basic Health will use your most recent income to determine your premium.

If you cannot provide IRS documentation (you are able to document that you did not have to file a tax return), we will use your most recent income documentation unless your income is seasonal. If Basic Health determines that your income is seasonal, we will use an average of your income over a period of several months, and you may be required to provide additional documentation.

**Self-employment or rental income**
If you are reporting self-employment or rental income, Basic Health will require that your premium be based on an average of your income, using a 12-month history of your self-employment or rental income and expenses, unless you have had the business or rental property for less than 12 months.

## Family changes

You may submit an application to enroll eligible family members to your Basic Health account during open enrollment, if income guidelines are met. At other times during the year, family members may be enrolled only if your status changes because of:

- Marriage (application must be received at Basic Health within 30 days of the marriage, even if your new spouse is not applying for coverage).
- Birth or adoption (application must be received by Basic Health within 60 days of the birth or placement for adoption of the child).
- Loss of other continuous coverage for which you previously either left Basic Health or waived Basic Health coverage (application must be received by Basic Health within 30 days of the loss and you will be required to provide proof of continuous coverage).
- Change in legal custody of a child or disabled dependent (application and proof of legal custody or guardianship must be received by Basic Health within 30 days of the custody change).

To apply to enroll a new family member call 1-800-842-7712 or visit Basic Health's Web site to request the *Family Changes Form*. Be sure to follow the instructions included with the form. You need to send Basic Health current documentation of family income, as well as information about any other changes that could affect your monthly premium.

If you do not provide the necessary form or documentation within the time frames stated above, the new family member will be added to your account for family size only (which may change your monthly premium), but not for medical coverage. To add a newborn or newly adopted child, you may also use the detachable *Change Form* included with your monthly billing statement.

***Separation or divorce.*** To report your separation or divorce, call 1-800-842-7712 or visit Basic Health's Web site to request a *Family Changes Form*. Be sure to follow the instructions included with the form. You need to send Basic Health current income information and proof of residency. If there are children on your account, you also need to send a copy of the court order determining a parent's custody or obligation to provide for the child's health care coverage.

When you notify Basic Health of a change in family size (such as a marriage, divorce, or death), you will be required to submit proof of your current income.

If your child is over age 19 and is listed on your account as a full-time student, he or she cannot remain on your account if he or she disenrolls from school (other than during breaks scheduled by the school) or if he or she begins attending part time. You must notify Basic Health within 30 days of the change in student status. Former students who were removed from their parents' account because they were no longer full-time students, may apply for their own account. If they did not have medical coverage under their parents' account when they apply for coverage (listed for

family size only or had a break in coverage), their enrollment may be delayed until space becomes available.

### Address changes

If you move or your address changes, you must provide Basic Health with your new address within 30 days. To do this, you may call Basic Health at 1-800-660-9840, complete the detachable *Change Form* included with your billing statement and return it with your payment, or write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683. Include your subscriber I.D. number, your name, new address and county, your old address, and your phone number. Be sure to say if your new address is permanent or temporary (less than six months), and if your mailing address is different from your street address.

If you move out of Washington State, you will no longer be eligible for Basic Health coverage and will be disenrolled. If you move out of your health plan's service area, you will be required to select a new health plan. Until your coverage can be transferred to a health plan that serves the area where you live, you will need to travel to the area served by your old health plan for any services except emergency services.

**Please note:** Basic Health routinely verifies addresses with the U.S. Postal Service, so please be sure to file a change of address with your post office as well.

### Changing health plans

Open enrollment is usually the one time during the year that you can change your health plan (if you have more than one plan available in your area) or enroll additional family members who meet income and eligibility requirements. Basic Health will send you open enrollment materials, which will indicate the effective date of these changes and provide information on available health plans and the monthly premium for each. You'll be notified prior to each upcoming open enrollment period and given instructions for making changes.

Other than during open enrollment, you may only change health plans in very limited conditions. For example: You may be given an opportunity to change health plans if you move to a county where your current health plan is not offered or would cost you more, or a health plan is available to you that was not previously available. You will not be allowed to change health plans if your only reason is that a provider you want to see is no longer participating with your health plan. However, an exception may be made in some cases, if you are able to prove that you need to continue a current course of treatment with a specific provider that is no longer with your health plan. When you are given an opportunity to change health plans, remember that each health plan contracts with different providers and has its own prescription drug formulary (list of covered drugs). You should call the health plan or your provider to find out if your provider contracts with the health plan you are considering. If you take any prescription medications, you also should contact the health plan you are considering to see if your medications will be covered.

If you change health plans, any services you had approved under your previous health plan will need to be reviewed and approved again by your new health plan. Check with your health plan for further information.

While Basic Health is committed to ensuring that your health plan is available throughout the calendar year, should your health plan become unavailable during the year, you will be permitted to choose among the remaining plans in your county. If only one plan remains, you will be assigned to that health plan.

### Basic Health for Groups

If you are enrolled in a group account, make sure your employer or sponsor is aware of any changes in your income or family circumstances; either you

or your employer or sponsor must promptly notify us of those changes.

If you are enrolled in a group account through your employer, a change in your income or family size may affect the amount you are required to contribute toward your coverage. Contact your employer or payroll officer if you have questions about those changes.

If you are no longer eligible for employer, home care agency, or financial sponsor group coverage and you still meet income guidelines, Basic Health will offer you coverage under an individual account. You will be required to pay the premium for your continued coverage.

If you are transferring from an individual account to a group account, or vice versa, contact Basic Health to promptly notify us of the change.

## Suspension, Disenrollment, and Re-enrollment

You may disenroll from Basic Health or Basic Health *Plus* coverage for yourself, a family member, or your entire family at any time by notifying Basic Health by phone at 1-800-660-9840, or in writing (P.O. Box 42683, Olympia, WA 98504-2683). The notification must include:

- Your name and Basic Health subscriber I.D. number;
- The name of each person you are disenrolling;
- Reason for disenrolling (especially if due to other insurance, Medicare, or Medicaid); and
- The month you want coverage to end. Coverage will end the last day of the month you indicate, but no sooner than the next coverage month. To qualify for a refund of your premium payment, we need to receive your request to disenroll at least 10 days before the first of the month the payment was to have covered.

If you voluntarily disenroll from coverage, any remaining family members may continue with Basic Health. Remaining family members enrolled in Basic Health *Plus* or the Maternity Benefits Program through DSHS may stay with that program as long as they are eligible, even if your coverage is suspended or you are disenrolled from Basic Health for failing to pay your required premium.

You will lose your Basic Health coverage if you:

- Move out of Washington State or leave the state for more than six months in a row.
- Become eligible for either free or purchased Medicare coverage.
- Have income above Basic Health's income guidelines.
- Do not pay the required premium when due, or your employer or financial sponsor does not pay the required premium when due. When this happens, your coverage will be suspended (meaning you will lose your coverage for one month but still have the option of returning to coverage). If your coverage is suspended three times in a 12-month period or you fail to pay your premium by the due date on the Notice of Suspension, you and your family members will be disenrolled from Basic Health and will not be allowed to re-enroll for at least 12 months.
- Do not pay the amount due for recoupment of a subsidy overpayment or penalties by the due date (see "Recoupment" on page 6).
- Do not provide information Basic Health requests to verify your eligibility or income.
- Engage in any form of fraud against Basic Health or your health plan or its providers, or knowingly provide information to Basic Health that you know or think may be false or misleading, or fail to supply information you are required to provide, such as a change in income or family size.

You also may be disenrolled from Basic Health if you:

- Pose a risk to the safety or property of Basic Health or your health plan, or their staff, providers, patients, or visitors.
- Refuse to accept or follow procedures or treatment recommended by your PCP and determined by your health plan's medical director to be essential to your health (or the health of your child), and you have been told by your health plan that no other treatment is available.
- Have repeatedly failed to pay copayments on time.

The above conditions for loss of eligibility also apply to family members enrolled on your Basic Health account.

If your coverage ends, you'll receive a written notice describing the reason and the date your coverage will end.

### Basic Health for employer Groups

When your employer coverage ends, you may be eligible for continuing coverage through COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985). Under COBRA, you would be able to continue your coverage for up to 18 months; however, you will have to pay the full cost of your coverage, including any premium share that had been paid by your employer. Contact your employer directly to find out if you are eligible for COBRA coverage.

### How to re-enroll

Re-enrollment procedures differ based on the reason your coverage ended and the time since you last had coverage. At the time you re-apply for Basic Health, you may be required to submit a new application, new documentation of income and residency, and proof of other continuous coverage. Because Basic Health enrollment is limited, you may have to wait until space is available before you can re-enroll.

Generally, when you disenroll from Basic Health, you will be required to wait at least 12 months before you can apply for re-enrollment, and your enrollment may be delayed further if the enrollment limit has been reached. However, the 12-month wait for re-enrollment may be waived if:

- You left for other coverage, and you re-apply for Basic Health within 30 days of losing other continuous coverage (you will be required to provide proof of continuous coverage); or
- You move out of the state, then move back and establish residency; or
- You were disenrolled because you were no longer eligible for Basic Health coverage, but you have now become eligible for coverage.

Although the 12-month wait for re-enrollment could be waived, your enrollment may still be delayed if Basic Health's enrollment limit has been reached.

# Chapter Four:
# What's Covered?

## Covered services and supplies

The listing of services covered under Basic Health, called the "Schedule of Benefits," is contained in Appendix A of this handbook. If you have questions about a particular medical condition or Basic Health benefit, contact your health plan directly at the number listed on the inside front cover of this handbook.

## Preexisting condition waiting period

Generally you must wait nine months from the day your coverage begins before Basic Health will cover preexisting conditions (as defined below), except for maternity care and prescription drugs. For more information, refer to "Limitations and exclusions" on page 30.

- A preexisting condition is defined as an illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:
  - Treatment, consultation, or a diagnostic test was recommended for or received by the member; or
  - Medication was prescribed or recommended for the member; or
  - Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment.
- If you were enrolled in health care coverage that was similar to Basic Health at any time during the three months just before you applied for or were enrolled in Basic Health, your waiting period for treatment of a preexisting condition may be waived or shortened as described in "Limitations and exclusions," page 30.
- If your enrollment was delayed due to the Basic Health enrollment limit, you may receive up to three months credit toward the waiting period.

**For organ transplants:**
You must be enrolled in Basic Health for 12 months in a row before you will be covered for organ transplant procedures for a preexisting condition. Further information on the waiting period for organ transplant procedures is provided in the Basic Health "Schedule of Benefits" on pages 24–25.

## If you need emergency care

Emergency care is covered 24 hours a day, seven days a week. (For additional information, including a definition of "emergency," refer to pages 25–26 of this handbook.) To receive benefits from your health plan for emergency care, it is important to follow these steps:

- **Depending on the severity of the problem, go directly to the nearest emergency room, call 911, or call your PCP.**
- **If you are admitted to a hospital or other health care facility, call (or have a friend, family member, or staff member call) your health plan or PCP within 24 hours or as soon as is reasonably possible.**
- **See (or be referred by) your PCP for follow-up care.**

**Important:** If you do not follow these instructions, your coverage for emergency services may be limited to the amount that would have been paid if you had notified your PCP. (See "Emergency Care" on pages 25–26.) You are responsible for paying any balance. If the case is determined not to be an emergency (whether or not you follow the instructions), you will be responsible for all costs.

## If you are pregnant

If you become pregnant, call 1-800-660-9840 right away to notify Basic Health of your pregnancy.

We will mail a Basic Health *Maternity Benefits Application* for you to complete. The Maternity

Benefits Program is a Medicaid program jointly administered with the Department of Social and Health Services' (DSHS) Medical Assistance Administration (MAA). The program allows you to receive maternity benefits through the same health plan you choose for your Basic Health coverage. When you are choosing a provider for your maternity services, you should always verify that the provider contracts with your chosen health plan to provide Maternity Benefits Program services through Basic Health.

DSHS determines eligibility for the Maternity Benefits Program based on Medicaid eligibility criteria. Medicaid will require a written verification of the pregnancy from a licensed doctor, nurse, or medical laboratory, and will ask for an estimated due date. Home pregnancy tests are not accepted for proof of pregnancy.

**Basic Health provides coverage for maternity services for only 30 days after your doctor verifies your pregnancy, unless you apply for the Maternity Benefits Program**. You must submit your Basic Health *Maternity Benefits Application* within 30 days after your pregnancy is verified to continue maternity coverage. If you do not apply for the Maternity Benefits Program, you will be responsible for the full costs of all maternity services received more than 30 days after your pregnancy is verified.

MAA will tell you if you are or are not eligible for the Maternity Benefits Program. Once your enrollment in the Maternity Benefits Program is complete, you will not have monthly premiums or copayments, and you will continue to receive your care from the health plan you chose through Basic Health. However, you will need to continue paying your Basic Health premiums until the effective date of your enrollment in the Maternity Benefits Program. Your enrolled family members will still be covered through Basic Health, and you will still be responsible for paying their premiums.

If you do not meet citizenship requirements for the Maternity Benefits Program, you may be eligible for other MAA programs that cover maternity care. To receive these benefits through other MAA programs, you must report your pregnancy to Basic Health and provide written verification of your pregnancy.

If you have completed the application process for the Maternity Benefits Program and submitted all the required documentation, but you have been told you are not eligible for the Maternity Benefits Program, Basic Health will cover maternity services you receive while you are enrolled in Basic Health. However, before these costs will be paid, Basic Health must receive a copy of your denial notice from the MAA.

The Maternity Benefits Program allows you to receive other services often referred to as "First Steps." Information about this program is available in a separate document called "Basic Health *Plus* and the Maternity Benefits Program." A copy of this document will be provided to you when you are enrolled in the Maternity Benefits program. If you do not receive a copy, please contact us and we will send one to you.

### When your pregnancy ends

Once your pregnancy ends, it is very important that you notify Basic Health at 1-800-660-9840 right away. An application to add your newborn child to your Basic Health account will be mailed to you. To avoid a break in coverage, Basic Health must receive your completed application to add your newborn's coverage within 60 days of the child's birth.

Your medical coverage will resume under Basic Health at the end of your MAA maternity benefits coverage only if your family's Basic Health premiums (if any) have been paid while you were enrolled in the Maternity Benefits Program. For example, if you have a spouse and/or dependent(s) enrolled in Basic Health and they are disenrolled for nonpayment while you are covered through the

Maternity Benefits program, your coverage will continue until the end of your pregnancy. However, at that point, you will lose your coverage, and you and your family (except for children enrolled in Basic Health *Plus*) will not be able to re-enroll in Basic Health until 12 months from the date of your family's disenrollment. In addition, if Basic Health enrollment limits have been reached, you may be required to wait until space is available.

You must also notify Basic Health at the end of your child's pregnancy within 60 days of the birth (use the *Family Changes Form* or the *Change Form* included with your billing statement to continue the newborn's coverage). To continue coverage for her newborn, your child may also need to enroll under her own account.

**Please note**: Even though you must notify Basic Health of the pregnancy, your child does not need to apply for additional maternity benefits coverage if she is covered under Basic Health *Plus*. Her maternity services will be covered through Basic Health *Plus*.

## The right to exercise conscience

Religiously sponsored health plans, health care providers, or employers have the right not to provide benefits or services for termination of pregnancy or other services to which they object because of religious belief or issues of conscience. If your health plan or employer objects to providing a specific service that is normally provided, you will be told how to receive this particular service from another provider, with no added cost to you. Contact your health plan for more information.

If you object to having coverage for termination of pregnancy or other services, you may notify Basic Health in writing. Benefits will not be provided to you for those services; however, your premium will not change.

# Chapter Five:
# Common Problems

## What if I receive a bill for covered services?

If you receive care from a doctor or other provider who contracts with your health plan, the provider will usually bill the health plan directly. However, you may receive a bill from a provider who does not contract with your health plan, or from a provider who did not know about your Basic Health coverage. (When you fill out information for your provider, be sure to list the health plan that provides your coverage–not Basic Health.) If you receive a bill for services that you think are covered by Basic Health, send the bill directly to your health plan at the address on your I.D. card. (Call your health plan at the number listed in the front of this book for details.) Benefits may be denied if your health plan receives the bill more than 12 months after the date you received services. If you have questions about whether the services are covered, call your health plan.

## What do I do if a third party is responsible for my injury or illness?

You or your representative are required to notify your health plan if your provider charges the health plan for treatment of an injury or illness that is the result of another person's or organization's action or failure to act (for example, a fall, an auto accident, or an accident at work). The other person or organization responsible for your injury or illness is called the "third party."

You must notify your health plan promptly, in writing, of all of the following:

- **The facts of the injury or illness, including the name and address of any third party you think may be responsible for the injury or illness;**
- **The name and address of the third party's insurance company, if they are insured;**
- **The name and address of attorney(s), if any, who will be representing the third party;**
- **If you plan to file a claim or lawsuit against the third party, the name and address of the person who will be representing you;**
- **Adequate advance notice of any trial, hearing, or possible settlement of your claim against the third party;**
- **Any changes in your condition or injury; and**
- **Any additional information reasonably requested by the health plan.**

If you bring a claim or legal action against a liable third party, you must seek recovery of the benefits paid by your health plan.

After you have been fully compensated for all damages you experienced as a result of the accident, your health plan has a right to reimbursement up to the amount of the benefits the health plan has paid, from any recovery you receive. You are required to pay the health plan only the amount that is left over after you have been fully compensated for all of your damages (including pain and suffering and lost wages), up to the amount of the benefits paid.

If your health plan seeks to recover benefits directly from the third party, you must cooperate fully and must not do anything to impair your health plan's right of recovery. Your health plan may bring suit against the third party in your name, or may join as a party in a lawsuit or claim you have filed. Your health plan will not be required to pay for legal costs you incur, and you will not be required to pay legal costs incurred by your health plan. However, your health plan may agree to share the cost if they choose to be represented by your attorney.

You could be disenrolled from Basic Health for "intentional misconduct" if you:

- Withhold from your health plan information you

have about a legally responsible third party; or

- Refuse to help your health plan collect from that legally responsible third party.

## How do I file a complaint or appeal?

If you have a complaint or appeal about services from your health plan, its providers, or benefits, contact your health plan directly. You can find their toll-free number on the inside front cover of this book. If you have a complaint about an action taken by Basic Health, call 1-800-660-9840. If you speak to a representative from Basic Health or your health plan, it is helpful if you note the date of the call, the name of the representative, and whether the representative was with Basic Health or your health plan.

### Complaints or disputes with your health plan

Your health plan is required to provide you information on its complaint and appeal process when you enroll, when you report a complaint, and with the health plan's notice of an appeal decision.

If you disagree with a decision made by your health plan (such as denial of a claim or benefits interpretation) or have a complaint regarding your health plan's services, providers, or facilities, you must follow your health plan's procedures for resolving disputes. Basic Health staff are available to help you resolve the issue informally, but the matter cannot be appealed to Basic Health. If you file a complaint against a health plan's service, provider, or facility, state law limits the information the health plan may provide you regarding the resolution.

If you file a complaint or appeal with your health plan, the health plan must respond within 30 days after receiving it. This response may be a decision or notification of a reason for a delay. However, unless you agree to an additional delay, the decision may not be delayed more than 30 days after the health plan receives your appeal. If waiting for a decision could jeopardize your health, make sure the health plan is aware of that so they can deliver a decision more quickly. Issues that would jeopardize your health must be decided within 72 hours after receiving the appeal.

If you have exhausted your health plan's complaint/appeal process and disagree with the health plan's decision, or if your health plan has not responded to your request within 30 days, you have the right to request a review of the decision by an Independent Review Organization. This can also be done through your health plan. Your health plan is required by law to provide the Independent Review Organization with all information on which the decision was based within three business days of receiving the request. You may also be required to provide additional information or documentation needed for the Independent Review Organization's decision.

### Complaints or disputes with Basic Health

If you have a complaint or want an explanation of an action taken on your account, write to Basic Health at P.O. Box 42683, Olympia, WA 98504-2683, or call toll-free 1-800-660-9840. A representative will try to resolve your issue.

If you disagree with a Basic Health decision, such as a denial of eligibility, premium, premium adjustment or penalty, change of health plan, or loss of Basic Health membership, you may file a written appeal with Basic Health within 30 days of the notice of the decision. Write to Basic Health Appeals, P.O. Box 42690, Olympia, WA 98504-2690, stating you want to file an appeal. Your letter must include your name, address, Basic Health subscriber I.D. number, a daytime phone number, a summary of the decision you are appealing and a statement explaining why you believe the decision was incorrect. You must also include copies of any evidence that will help

explain or prove that the decision should be changed. If your appeal is not received within 30 days of the notice of the decision, you will forfeit your right to appeal that decision.

In your appeal you may ask to explain in person or by phone why you believe the decision was incorrect and should be changed. Be sure to let us know if you will need an interpreter and, if so, what language and dialect you speak. Also let us know if you will need any assistance due to disability.

Within five days of receiving your letter, Basic Health will confirm that your appeal was received. If you have asked for a chance to explain your appeal over the phone or in person, our Appeals Department will contact you to schedule a conference. The conference will be recorded to ensure an accurate record, and you will be questioned as well as given an opportunity to explain your point of view. You should be prepared to give detailed information to support your opinion that the decision was in error.

Your appeal will be reviewed carefully, and Basic Health will mail a written notice of the decision to you within 60 days of receiving your appeal. If additional time is required for investigation of your appeal, you'll be notified in writing and a decision date will be set.

If you disagree with Basic Health's decision on your appeal, you may request a further review of that decision by writing to: Basic Health Appeals, P.O. Box 42690, Olympia, WA 98504-2690. Basic Health must receive your request for review within 30 days of the date on the notice of Basic Health's appeal decision. You should explain that you are requesting a review of Basic Health's appeal decision. Also provide a summary of the decision you are contesting, why you believe the decision was incorrect, any information not included in your original appeal that you believe needs to be considered, and a daytime phone number where we can reach you. In addition, the request must include all evidence that has not yet been provided and on which you will rely to explain why you believe Basic Health acted incorrectly. If your request for review is not received within 30 days of the notice of the appeal decision, you will forfeit your right for a review.

The Office of Administrative Hearings will review Basic Health's appeal decisions regarding disenrollment due to nonpayment. A presiding officer appointed by the Administrator of the Health Care Authority will review Basic Health's appeal decisions on all other issues, based on the record of the appeal and any evidence you send. Be sure to include all information you want considered. The presiding officer may contact you for further information. The HCA will notify you in writing of the final decision.

# Appendix A:
# Schedule of Benefits

This "Schedule of Benefits" lists benefits for Basic Health members who are eligible for Basic Health. Services are subject to all provisions of this "Schedule of Benefits," including limitations, exclusions, and copayments. Except as specifically stated otherwise, all services and benefits under Basic Health must be provided, ordered, or authorized by the health plan or its contracting providers. Even if your provider authorizes a service, your health plan may also need to preauthorize the care.

If you have a question about the benefits listed, or are not sure if a service is covered, you should call the health plan's customer service department.

## I. Medically Necessary Services, Supplies or Interventions

Basic Health provides coverage for services, supplies or interventions that are otherwise included as a "covered service," as set forth in Section II, that are not excluded and are medically necessary. A service is "medically necessary" if it is recommended by your treating provider and your health plan's Medical Director or provider designee and if all of the following conditions are met:

1. The purpose of the service, supply or intervention is to treat a medical condition;
2. It is the most appropriate level of service, supply or intervention considering the potential benefits and harm to the patient;
3. The level of service, supply or intervention is known to be effective in improving health outcomes;
4. The level of service, supply or intervention recommended for this condition is cost-effective compared to alternative interventions, including no intervention; and
5. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion.

- A health "intervention" is an item or service delivered or undertaken primarily to treat (i.e., prevent, diagnose, detect, treat, or palliate) a medical condition (i.e., disease, illness, injury, genetic or congenital defect, pregnancy, or a biological or psychological condition that lies outside the range of normal, age-appropriate human variation) or to maintain or restore functional ability. For purposes of this definition of "medical necessity," a health intervention means not only the intervention itself, but also the medical condition and patient indications for which it is being applied.
- "Effective" means that the intervention, supply or level of service can reasonably be expected to produce the intended results and to have expected benefits that outweigh potential harmful effects.
- An intervention, supply or level of service may be medically indicated yet not be a covered benefit or meet the standards of this definition of "medical necessity." Your health plan may choose to cover interventions, supplies, or services that do not meet this definition of "medical necessity," however, the health plan is not required to do so.
- "Treating provider" means a health care provider who has personally evaluated the patient.
- "Health outcomes" are results that affect health status as measured by the length or quality (primarily as perceived by the patient) of a person's life.

- An intervention is considered to be new if it is not yet in widespread use for the medical condition and patient indications being considered.
- "New interventions" for which clinical trials have not been conducted because of epidemiological reasons (i.e., rare or new diseases or orphan populations) shall be evaluated on the basis of professional standards of care or expert opinion (See "existing interventions" below).
- "Scientific evidence" consists primarily of controlled clinical trials that either directly or indirectly demonstrate the effect of the intervention on health outcomes. If controlled clinical trials are not available, observational studies that demonstrate a causal relationship between the intervention and health outcomes can be used. Partially controlled observational studies and uncontrolled clinical series may be suggestive, but do not by themselves demonstrate a causal relationship unless the magnitude of the effect observed exceeds anything that could be explained either by the natural history of the medical condition or potential experimental biases.
- For "existing interventions," the scientific evidence should be considered first and, to the greatest extent possible, should be the basis for determinations of "medical necessity." If no scientific evidence is available, professional standards of care should be considered. If professional standards of care do not exist, or are outdated or contradictory, decisions about existing interventions should be based on expert opinion. Giving priority to scientific evidence does not mean that coverage of existing interventions should be denied in the absence of conclusive scientific evidence. Existing interventions can meet the Basic Health definition of "medical necessity" in the absence of scientific evidence if there is a strong conviction of effectiveness and benefit expressed through up-to-date and consistent professional standards of care or, in the absence of such standards, convincing expert opinion.
- A level of service, supply or intervention is considered "cost effective" if the benefits and harms relative to costs represent an economically efficient use of resources for patients with this condition. In the application of this criterion to an individual case, the characteristics of the individual patient shall be determinative. Cost-effective does not necessarily mean lowest price.

## II. Covered services

The following services are covered when they are medically necessary. All services, supplies and interventions are subject to the appropriate copayment at time of service. (See Section III. Copayments.)

**A. Hospital care**
**The following hospital services are covered:**

1. Semi-private room and board, including meals; private room and special diets; and general nursing services.
2. Hospital services, including use of operating room and related facilities, intensive care unit and services, labor and delivery room when eligible for Basic Health maternity benefits, anesthesia, radiology, laboratory and other diagnostic services.
3. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, nursery and laboratory services.
4. Drugs and medications administered while an inpatient.

5. Special duty nursing.

6. Dressings, casts, equipment, oxygen services, and radiation and inhalation therapy.

If a member is hospitalized in a non-contracting facility, the health plan has the right to require transfer of the member to a contracting health plan facility at the health plan's expense, when the member's condition is sufficiently stable to enable safe transfer.

If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

Personal comfort items such as telephone, guest trays, and television are not covered.

**B. Medical and surgical care**

The following medical and surgical services are covered. The health plan may require that certain medical and surgical services be provided on an outpatient basis.

1. Surgical services.

2. Radiology, nuclear medicine, ultrasound, laboratory, and other diagnostic services.

3. Dressings, casts, and use of cast room; anesthesia and anesthesia-related oxygen services.

4. Blood, blood components and fractions (such as plasma, platelets, packed cells, and albumin), and their administration.

5. Provider visits, including diagnosis and treatment in the hospital, outpatient facility, or office; consultations, treatment, and second opinions by the member's PCP, or by a referral provider. Normal newborn baby care following birth while in a contracting facility when not eligible for coverage under the "Maternity care" benefit. Covered services include, but are not limited to, routine newborn exams and laboratory services.

   Pharmaceuticals that are or would normally be an intrinsic part of a provider visit (inpatient or outpatient) are covered as part of the provider visit.

6. Radiation therapy; chemotherapy.

7. Inpatient and outpatient chiropractic and physical therapy services are covered to a combined maximum of six visits per calendar year, and are covered for only post-operative treatment of reconstructive joint surgery when received within one year following surgery. Diagnostic or other imaging procedures solely for determination of therapy services are not covered. Covered chiropractic services may be referred or self-referred to contracted providers.

8. Prescription drugs and medications as defined in "Pharmacy benefit."

9. Family planning services provided by the member's PCP or women's health care provider. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps, and long-acting progestational agents) determined most appropriate by the PCP or women's health care provider for use by the member are also covered. Over-the-counter supplies such as condoms and spermicides are covered only when part of a health plan protocol at the health plan's discretion. Elective sterilization is covered.

**C. Maternity care**

Pregnant Basic Health members who are determined to be eligible for medical assistance through the Department of Social and Health Services (DSHS), Basic Health only covers maternity care services for a period not

to exceed 30 days following diagnosis of pregnancy.

The following maternity care services are covered for members who are determined to be ineligible for medical assistance through the DSHS: diagnosis of pregnancy; full prenatal care after pregnancy is confirmed; delivery; postpartum care; care for complications of pregnancy; preventive care; physician services; hospital services; operating or other special procedure rooms; radiology and laboratory services; medications; anesthesia; normal newborn care following birth, such as but not limited to, nursery services and pediatric exams; and termination of pregnancy (including voluntary termination of pregnancy).

**D. Chemical dependency**
Members are eligible to receive residential and outpatient chemical dependency treatment from a health plan-contracting approved treatment program to a maximum benefit of $5,000 in a 24 consecutive calendar month period up to a lifetime benefit maximum of $10,000. Covered residential and outpatient treatment includes services such as diagnostic evaluation and education, and organized individual and group counseling. The hospital copayment applies to intensive inpatient services. Outpatient copayments for residential (other than intensive inpatient) and intensive outpatient services shall not exceed the hospital stay copayment. Health plans may use lower copayments, if applicable, for group sessions. (**NOTE:** Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity.")

In determining the $5,000 limit, the health plan reserves the right to take credit for chemical dependency benefits paid by any other group medical plan on behalf of a member during the immediate preceding 24 consecutive calendar month period. In determining the $10,000 lifetime limit, the health plan reserves the right to take credit for chemical dependency benefits paid under Basic Health on behalf of the member from January 1, 1988.

**E. Mental health services**
Mental health services are covered as follows:

Inpatient care in a participating hospital or other appropriate licensed facility approved by the health plan is covered in full (subject to copayment) up to 10 days per calendar year.

Outpatient care, including individual and family counseling, is covered in full up to 12 visits per calendar year after the copayment per visit for individual sessions. Health plans may use lower copayments, if applicable, for group sessions. Visits for the sole purpose of medication management are exempted from the 12-visit limit, and are instead covered as other provider visits.

(**NOTE:** Court-ordered treatment will be covered only if determined by the health plan to meet the Basic Health definition of "Medical Necessity.")

**F. Organ transplants**
Services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery, and follow-up care, are covered. This benefit includes covered donor expenses.

Heart, heart-lung, liver, bone marrow including peripheral stem cell rescue, cornea, kidney, and kidney-pancreas human organ transplants are covered when the Basic Health definition of "Medical Necessity" is met.

**Organ transplant recipient:** All services and supplies related to the organ transplant for the

member receiving the organ, including transportation to and from a health plan-designated facility (beyond that distance the member would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided the member has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

**Organ transplant donor:** The donor's initial medical expenses relating to harvesting of the organ(s), as well as the costs of treating complications directly resulting from the procedure(s), are covered, **provided the organ recipient is a member of the health plan**, and provided the donor is not eligible for such coverage under any other health care plan or government-funded program.

**Waiting period:** Members must be enrolled in Basic Health for 12 consecutive months before they are eligible to receive benefits for covered transplant procedures. The waiting period applies to the transplant procedure including any immediate pre- and post-operative hospital care related to the transplantation, but does not apply to ongoing follow-up care including prescription drugs.

If a member satisfies the 12 consecutive months waiting period (no breaks in coverage for 12 consecutive months) and subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

**The waiting period will not apply:**

1. If the transplant is required due to a condition which is not a preexisting condition;
2. For children enrolled in and continuously covered by Basic Health from birth; or
3. For children placed in the home for purposes of adoption within 60 days of birth and continuously covered by Basic Health from the date of placement, provided one or both of the adoptive parents or family members are enrolled in Basic Health at the time of placement in the home.

If a newborn child enrolled from birth, or a newborn-adoptive child enrolled within 60 days of placement, subsequently has a break in Basic Health coverage, full credit will be given toward the waiting period if the break in coverage is not longer than one month. A member may not have more than two such one-month breaks in coverage during a 12-month period for full credit to continue.

**Limitations:** Transplants that are not preauthorized or are not performed in a health plan-designated medical facility are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

All services are subject to the appropriate copayment at the time of service.

**G. Emergency care**

An emergency is a sudden or severe health problem that needs treatment right away; there is not time to talk to your doctor.

"Emergency" is defined as:

> "The emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious

dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy."

The health plan reserves the right to determine whether or not the symptoms indicate a medical emergency. Acute detoxification is covered for up to 72 hours.

1. **In-service-area emergency.** In the event a member experiences a medical emergency, care should be obtained from a health plan-contracting provider. If, as a result of such emergency, the member is not able to use a health plan-contracting provider, the member may obtain emergency services from non-contracting health care providers. Follow-up care must be provided or approved by the health plan in advance. In the case of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If you fail to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider had notification requirements been met. The member will be financially responsible for any remaining balance.

2. **Out-of-service-area emergency.** The health plan shall bear the cost of out-of-service-area emergency care for covered conditions. In the event of emergency hospitalization, the member, or person assuming responsibility for the member, must notify the health plan within 24 hours of admission, or as soon thereafter as is reasonably possible. If you fail to meet the notification requirements, coverage will be limited to what would have been payable by the health plan to a health plan-contracting provider, had notification requirements been met. The member will be financially responsible for any remaining balance.

   The health plan may, at its discretion, appoint a consultant when out-of-service-area care is necessary, who will have authority to monitor the care rendered and make recommendations regarding the treatment plan. The health plan may otherwise secure information which it deems necessary concerning the medical care and hospitalization provided to the member for which payment is requested.

3. **Transfer and follow-up care.** If a member is hospitalized in a non-contracting facility, the health plan reserves the right to require transfer of the member to a health plan-contracting facility, when the member's condition is sufficiently stable to enable safe transfer. If the member refuses to transfer to a contracting facility, all further costs incurred during the hospitalization are the responsibility of the member.

   Follow-up care that is a direct result of the emergency must be obtained from a health plan-contracting provider, unless a health plan-contracting provider has authorized you to continue to receive follow-up care from another provider in advance.

4. **Prescription drugs.** Prescription drugs purchased from a non-contracting facility or pharmacy are covered subject to the applicable pharmacy copayment when dispensed or prescribed in connection with covered emergency treatment.

5. **Emergency ambulance transportation.** Medically necessary ambulance transportation is covered in an emergency, or to transfer a member when preauthorized by the health plan.

**H. Skilled nursing and home health care benefits**
As an alternative to hospitalization in an acute care facility, the health plan, at its discretion, may authorize benefits for the services of a skilled nursing facility or home health care agency.

**I. Hospice services**
Hospice services are covered.

**J. Plastic and reconstructive services**
Plastic and reconstructive services (including implants) will be provided only under the following conditions:

1. To correct a physical functional disorder resulting from a congenital disease or anomaly;

2. To correct a physical functional disorder following an injury or incidental to covered surgery; and

3. For a member who is receiving benefits in connection with a mastectomy:

   - Reconstruction of the breast on which the mastectomy was performed;

   - Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

   - Prostheses (internal and external) and physical complications of all stages of mastectomy.

   - Treatment of lymphedemas is covered; however, durable medical equipment and supplies used to treat lymphedemas may be covered only in limited circumstances. Please contact your health plan for specific coverage information.

**K. Preventive Care**
Preventive care services are covered, and will be provided as described in the schedule provided to you by the health plan.

**L. Pharmacy benefit**
The health plan may limit the drugs covered through use of a list called a "formulary." Each health plan's formulary includes all major therapeutic classes of drugs. Drugs not in the formulary will be covered if the health plan's medical staff determines that no formulary drugs are an acceptable medication for the patient. If you have a question about the pharmacy benefit, are not sure if a drug is covered, or believe a nonformulary drug should be covered, you should call the health plan's customer service department for information.

Basic Health covers drugs (of all types, including prescribed creams, ointments, and injections) at the copayment levels shown.

Prescriptions are limited to a 30-day supply.

Drugs for cosmetic purposes are excluded unless preauthorized.

(See table on following page for more pharmacy copayment information.)

| Tier 1 | | Tier 3 |
|---|---|---|
| **Copayment: $3** | **Copayment: $7** | **Copayment: 50%** |
| **Covered Drugs: (Examples)**<br>Amoxicillin<br>Clotrimazole vaginal cream<br>Co-Trimoxazole<br>Diphenhydramine<br>Doxycycline<br>Erythromycin base<br>Erythromycin ethylsuccinate Insulin<br>Metronidazole<br>Nystatin (oral or topical) Permethrin<br>Prenatal vitamins | **Covered Drugs:**<br>Generic drugs contained in the health plan's formulary, except those included in Tier 1.<br>All oral contraceptives in the health plan's formulary.<br>Syringes and needles<br>Diabetic test strips<br>Lancets | **Covered Drugs:**<br>Brand-name drugs in the health plan's formulary. |

**M. Additional services**

Services in addition to those listed in this "Schedule of Benefits" may be provided at the sole discretion of the health plan through the health plan's medical management or case management program if providing the service will result in a lower total out-of-pocket cost to the health plan. Additional services may be subject to copayments and limitations. As an example, oxygen or enteral and parentral nutrition may be covered as benefit exceptions for individuals who would otherwise require hospitalization or for services which would result in a lower out-of-pocket cost to the health plan as determined by the health plan.

## III. Copayments

The member is responsible for paying any required copayment directly to the provider of a covered service unless instructed by the health plan to make payment to another party. Copayments must be paid in full at the time of service, or service may be denied or rescheduled.

Only those copayments specifically listed below are to be charged to members for covered services. Members may be charged a missed appointment fee by a provider if they continually fail to keep appointments, or if they repeatedly fail to give timely notice when it is necessary to cancel appointments.

| | |
|---|---|
| **Physician** | $10 per office or home visit; no copayment for maternity care. |
| **Hospital** | $100 per inpatient admission, $500 maximum per member per calendar year; no copayment for maternity care, or readmission for the same condition within 90 days. |
| **Outpatient facility** | |
| Non-emergency | $25 per non-emergency outpatient admission or facility visit; no copayment for maternity care, or readmission for the same condition within 90 days. |
| Emergency | $50, waived if an inpatient admission results. |
| **Lab & x-ray** | No copayment. |
| **Ambulance** | $50; no copayment when the health plan requires a member to transfer from a non-contracting facility to a contracting facility, or when transfer to and from a facility is required for the member to receive necessary services. |
| **Preventive care** | No copayment. |
| **Maternity care** | No copayment. If the member is eligible for the Maternity Benefits Program, maternity services can only be covered under Basic Health for 30 days following diagnosis of pregnancy. All other maternity services are covered only through the Department of Social and Health Services. |
| **Pharmacy** (See "Pharmacy benefit" for types of drugs covered in each tier.) | Tier 1: $3<br>Tier 2: $7<br>Tier 3: 50% |

# IV. Limitations and exclusions

## A. Limitations

### 1. Preexisting condition waiting period

(a) A preexisting condition is defined as: "Any illness, injury, or condition for which, in the six months immediately preceding a member's effective date of enrollment in Basic Health:

- Treatment, consultation, or a diagnostic test was recommended for or received by the member; or
- Medication was prescribed or recommended for the member; or
- Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care, or treatment."

(b) **Waiting period**

Basic Health will not provide benefits for services or supplies rendered for any preexisting condition during the first nine consecutive months following the member's effective date of coverage. A member will not be required to begin a new nine consecutive-month waiting period if:

- Coverage is suspended for not longer than one month during the waiting period, and
- The member does not have more than two (2) one-month breaks in coverage during the waiting period.

Coverage for preexisting conditions will not be available until the member is actually covered by Basic Health for a total of nine months.

If the member is confined in a health care facility for treatment of a preexisting condition at the time the member's nine-month waiting period ends, benefits for that condition will be provided only for covered services rendered after the end of the waiting period.

(c) **Exceptions to waiting period**

(i.) The following services are not subject to the waiting period:

- Maternity care.
- Prescription drugs as defined in "Pharmacy Benefit."

(ii.) Children born on or after the parent's or sibling's effective date of coverage who are enrolled within 60 days of the date of birth, and adopted children who are placed for adoption after the adoptive parent's or sibling's effective date of coverage who are enrolled within 60 days of placement with the adoptive parents, are not subject to the nine-month waiting period for preexisting conditions.

(d) **Credit toward the waiting period**

Credit toward the waiting period will be given:

- If Basic Health delays your enrollment (up to a maximum of three months) due to budgetary constraints, and you have been determined eligible.
- For any continuous period of time during which a member was covered under similar health coverage if:

- That coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under Basic Health, or within the three-month period immediately preceding enrollment in Basic Health; and
- The coverage terminated not later than the first of the month following the effective date of coverage in Basic Health.

If similar coverage was in effect both prior to the date of application or reservation and the date of enrollment, credit will be given for the longer period of continuous coverage.

"Similar coverage" includes Basic Health; all DSHS programs administered by the Medical Assistance Administration which have the Medicaid scope of benefits; the DSHS program for the medically indigent; Indian Health Services; most coverages offered by health carriers; and most self-insured plans.

2. Major disaster or epidemic. If the health plan is prevented from performing any of its obligations hereunder in whole or part as a result of major epidemic, act of God, war, civil disturbance, court order, labor dispute, or any other cause beyond its control, the health plan shall make a good faith effort to perform such obligations through its then-existing and contracting providers and personnel. Upon the occurrence of any such event, if the health plan is unable to fulfill its obligations either directly or through contracting providers, it shall arrange for the provision of alternate and comparable performance.
3. The benefits available under Basic Health shall be secondary to the benefits payable under the terms of any health plan which provides benefits for a Basic Health member except where in conflict with Washington State or federal law.

**B. Exclusions**

The services listed below are not covered:

1. Services that do not meet the Basic Health definition of "Medical Necessity" for the diagnosis, treatment, or prevention of injury or illness, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions.
2. Services not provided, ordered, or authorized by the member's health plan or its contracting providers, except in an emergency.
3. Services received before the member's effective date of coverage.
4. Custodial or domiciliary care, or rest cures for which facilities of an acute care general hospital are not medically required. Custodial care is care that does not require the regular services of trained medical or allied health care professionals and that is designed primarily to assist in activities of daily living. Custodial care includes, but is not limited to, help in walking, getting in and out of bed, bathing, dressing, preparation and feeding of special diets, and supervision of medications which are ordinarily self-administered.
5. Hospital charges for personal comfort items; or a private room unless authorized by the member's health plan; or services such as telephones, televisions, and guest trays.

6. Emergency facility services for nonemergency conditions.
7. Charges for missed appointments or for failure to provide timely notice for cancellation of appointments; charges for completing or copying forms or records.
8. Transportation except as specified under "Organ transplants" and "Emergency care."
9. Implants, except: cardiac devices, artificial joints, intraocular lenses (limited to the first intraocular lens following cataract surgery), and implants as defined in the "Plastic and reconstructive services" benefit.
10. Sex change operations.
11. Investigation of or treatment for infertility or impotence.
12. Reversal of sterilization.
13. Artificial insemination.
14. In-vitro fertilization.
15. Eyeglasses, contact lenses (except the first intraocular lens following cataract surgery); routine eye examinations, including eye refraction, except when provided as part of a routine examination under "Preventive care;" and hearing aids.
16. Orthopedic shoes and routine foot care.
17. Speech, occupational and recreation therapy.
18. Medical equipment and supplies not specifically listed in this "Schedule of Benefits" except while the member is in the hospital (including but not limited to hospital beds, wheelchairs, and walk aids).
19. Dental services, including orthodontic appliances, and services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw, provided that such repair begins within ninety (90) days of the accidental injury or as soon thereafter as is medically feasible, provided the member is eligible for covered services at the time that services are provided.
20. Medical services, drugs, supplies, or surgery directly related to the treatment of obesity (such as but not limited to gastroplasty, gastric stapling or intestinal bypass).
21. Weight loss programs.
22. Cosmetic surgery, including treatment for complications of cosmetic surgery, except as otherwise provided in this "Schedule of Benefits."
23. Medical services received from or paid for by the Veterans Administration or by state or local government, except where in conflict with Washington State or federal law or regulation; or the portion of expenses for medical services payable under the terms of any insurance policy that provides payment toward the member's medical expenses without a determination of liability to the extent that payment would result in double recovery.
24. Conditions resulting from acts of war (declared or not).
25. Direct complications arising from excluded services.
26. Replacement of lost or stolen medications.
27. Evaluation and treatment of learning disabilities, including dyslexia.
28. Any service or supply not specifically listed

as a covered service unless medically necessary, prescribed by a contracting provider and authorized in advance by the health plan.

**C. Changes to covered services and premiums**

Basic Health may from time to time revise this "Schedule of Benefits." In designing and revising this "Schedule of Benefits," Basic Health will consider the effects of particular benefits, copayments, limitations and exclusions on access to medically necessary basic health care services, as well as the cost to members and to the state. Generally accepted practices of the health insurance and managed health care industries will also be taken into account.

Basic Health will provide you with written notice of any planned revisions to your Basic Health premiums or the benefit plan at least 30 days prior to the effective date of the change. This notice may be included with your premium statement, open enrollment materials or other mailing, or may be a separate notice. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first-class postage paid, directed to you at the mailing address you provided to Basic Health.

# Appendix B:
# A Guide to Terms Used in This Handbook

**Basic Health**
A health coverage program administered by the Health Care Authority (HCA).

**Basic Health *Plus***
A Medicaid program jointly administered with the Department of Social and Health Services (DSHS) Medical Assistance Administration for children under age 19 from low-income families. It provides expanded benefits (such as dental and vision care) and has no premiums or copayments. Eligibility for Basic Health *Plus* is determined by DSHS, based on Medicaid eligibility criteria.

**Certificate of coverage**
A description of your health care coverage and benefits. This handbook serves as your certificate of coverage.

**Copayment**
The portion of an expense you pay when you receive care.

**DSHS**
Department of Social and Health Services. The state agency which administers Medicaid and (along with the Health Care Authority) jointly administers Basic Health *Plus* and the Maternity Benefits Program.

**Dependent**
Same as family members.

**Disenrollment**
The process of losing Basic Health coverage due to nonpayment by the due date given in the notice of suspension, because of more than two suspensions in a 12-month period, or for failure to abide by any of your responsibilities as a Basic Health member.

**Enrollment**
The process of submitting completed application forms, being determined eligible, and being accepted into Basic Health, Basic Health *Plus*, or the Maternity Benefits Program.

**Family members**
Family members who should be listed as dependents on your account include your:

- Spouse living in the same household and not legally separated.
- Unmarried children, including stepchildren, legally adopted children, and children placed in your home for purposes of adoption or under your legal guardianship, who are:
  - Under age 19; or
  - Under age 23, if full-time students at an accredited school. You are required to send verification from the school each year when your dependent is age 19 through 22, to show that he or she is a full-time student. You must notify Basic Health within 30 days when your dependent over age 19 is no longer a full-time student.
- Your child, stepchild, or legal dependent of any age, who is not capable of self-support due to a disability. You may be required to provide documentation of your child's or stepchild's disability, and must provide documentation of legal guardianship for a disabled dependent who is not your child or stepchild.
- An unmarried child under age 19 who is living with you under an informal guardianship agreement and who is enrolled or enrolling for coverage on your account. You will be required to provide a copy of the agreement signed by the

parent, authorizing you to provide medical care for the child (this may be specific to medical care or may be authorization to provide all care and/or make all major decisions regarding the child). You must also include verification that you are providing at least 50 percent of the child's support.

### Formulary
An approved list of prescription drugs developed by each health plan.

### Health Care Authority (HCA)
The state agency responsible for Basic Health administration and coordinating with DSHS to provide Basic Health *Plus* and the Maternity Benefits Program.

### Health plan
An organization that offers health care coverage and contracts with the HCA to provide your care. You choose your health plan when you join Basic Health.

### Income
Your and your family's gross income (before deductions) as listed on page 9).

### Income band
Income levels A through H, as listed on page 9 and in the May 2003 Hot Policy Page. These levels, based on gross monthly income and family size, help determine monthly premiums.

### Income guidelines
The guidelines used to determine your eligibility for Basic Health and Basic Health *Plus*, and your monthly premium payments for Basic Health coverage. These income guidelines change annually. Refer to pages 9–11 for more information.

### Inpatient
A patient who is admitted for an overnight or longer stay at a health care facility and is receiving covered services.

### Maternity Benefits Program
The program coordinated with DSHS for eligible pregnant women. This program includes all Medicaid benefits, including maternity benefits, maternity support services, and maternity case management. Eligibility for the program is determined by the DSHS Medical Assistance Administration, based on Medicaid eligibility criteria.

### Medicaid
The federal aid program that provides medical coverage for persons in the DSHS categorically needy and medically needy programs.

### Medical Assistance Administration (MAA)
A unit of DSHS that is authorized to administer medical care programs. MAA and Basic Health jointly administer Basic Health *Plus* and the Maternity Benefits Program.

### Medicare
The federal health benefit program for people who are ages 65 and over, and for some people with disabilities. (If you are eligible for free or purchased Medicare coverage, you are not eligible for Basic Health.)

### Member
A person enrolled in Basic Health, Basic Health *Plus*, or the Maternity Benefits Program, and receiving coverage.

### Outpatient
A nonhospitalized patient receiving covered services away from a hospital such as in a physician's office or the patient's own home, or in a hospital outpatient or hospital emergency department.

**Personal eligibility statement (PES)**
The notice Basic Health sends you, showing the current status of your account. You will receive a PES when there is a change to your account. This statement may include a bill for additional premiums you must pay as a result of a change.

**Premium**
Your monthly payment for Basic Health coverage.

**Premium "lock-in"**
The period of time for which a member's premium will not change, unless the member has a qualifying change of circumstances (such as a job change, marriage, or divorce) or all Basic Health premiums change (such as with a new contract year). Premiums are "locked in" when a member's income has been calculated using income averaging.

**Primary care provider (PCP)**
Your personal provider. Your primary care provider can be a family or general practitioner, internist, pediatrician, or other provider approved by your health plan. To receive benefits, your primary care provider must provide or coordinate your care. If you need to see a specialist, your primary care provider will refer you.

**Provider**
A health care professional (such as a doctor, nurse, internist, etc.) or facility (such as a hospital, clinic, etc.).

**Recertification**
Periodic review of members' income and eligibility. During recertification, members are required to submit current income and residency documentation to verify their eligibility and/or level of premium subsidy.

**Recoupment**
When Basic Health bills a member for any premium subsidy overpaid because the member failed to accurately report income or income changes.

**Reduced-premium program**
Basic Health's health coverage program that offers members a lower-cost monthly premium, with the state paying a share of the monthly premium. The member's income must be less than the Basic Health income guidelines (based on their family size) to be eligible for the reduced-premium program.

**Service area**
The geographic area served by a health plan that is providing coverage for Basic Health members.

**Specialist**
A provider of specialized medicine, such as a cardiologist or a neurosurgeon.

**Student**
A person enrolled full time in an accredited secondary school, college, university, technical college, or school of nursing, as determined by the school registrar.

**Subscriber**
The person on a Basic Health account who is responsible for payment of premiums and copayments and to whom Basic Health sends all notices and communications. The subscriber may be a Basic Health member or the spouse, parent, or guardian of an enrolled dependent.

**Suspension of coverage**
The process of losing health coverage for a period of one month after a monthly premium has not been paid or has been paid after the

due date. If your coverage is suspended more than two times in a 12-month period, you will be disenrolled and cannot re-enroll for at least 12 months.

### Tier

A category of drugs related to the pharmacy benefit. Your cost for prescriptions depends on the category (or tier) the prescription falls within. (For example, Tier 1 is in the category of prescriptions that costs you the least.)

### Washington resident

A person physically residing and maintaining an abode in the state of Washington.

# Income Worksheets

- Monthly Income Worksheet
- Self-Employment/Rental Income Worksheet

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# MONTHLY INCOME WORKSHEET

Follow the instructions beginning on page 3. If you have rental or self-employment income, you may also be required to fill out the *Self-Employment/Rental Income Worksheet* on the other side of this form.

❑ Check here if you want your monthly Basic Health premium based on the most recent three consecutive months' income. Be sure to attach proof of each source of income for all three months. Read page 3 of the instructions.

**Do not send original documents. They cannot be returned to you.**

| Income source | Income received | Family member who received this income: | Send a copy of: |
|---|---|---|---|
| Wages, salary, commissions, or tips for the most recent 30 days or full calendar month | $ | | Pay stubs. (If your pay stub does not show the amount you received as tips, include a signed and dated statement from your employer, indicating the amount you earned in tips.) |
| Self-employment or rental profit or loss, if applicable (from your IRS Form 1040 or line 32 of the *Self-Employment/Rental Income Worksheet*)<br>UBI number: | $ | | Your most recently filed federal income tax return (IRS Form 1040) and all applicable schedules. (If you were not required to file a tax return or are asking us to use less than 12 months of information, complete and send the *Self-Employment/Rental Income Worksheet*.) |
| Unemployment compensation | $ | | Check stubs. |
| L&I (workers' compensation) | $ | | Award letter showing your current gross monthly benefits. |
| Child support, family support, alimony | $ | | ◗ Checks;<br>◗ Court documents indicating the amount awarded; ***or***<br>◗ Office of Support Enforcement (DSHS) statement. |
| Social security or supplemental security income | $ | | Benefits statement received at the beginning of the current year. |
| Public assistance (includes DSHS grants) | $ | | Copy of the award letter showing your monthly benefit and dates received. |
| Retirement income or pension | $ | | ◗ Pay stub; ***or***<br>◗ Award letter or benefit statement showing your current monthly benefit.<br>◗ Military cost of living allotment statement. |
| Other (please describe; see instructions with this application) | $ | | Read the instructions to find out what to send. |
| Subtotal: | $ | | |
| Subtract work-related dependent care expenses (see instructions): | —$ | | Receipts, canceled checks, or credit card invoices for work-related dependent care expenses, or the child support order showing the amount for child care expenses and the canceled check covering the most recent month. Include the name, address, and phone number of the dependent care provider. |
| Total gross monthly income: | $ | | IRS Form 1040 and schedules, or transcript or proof of nonfiling status (see the instructions). |

**If you or your spouse are reporting no income, you must briefly state how you supported yourself and then sign below.**

| Signature | Name (please print or type) | Date |
|---|---|---|
| | | / / |
| Signature of spouse | Name (please print or type) | Date |
| | | / / |

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## SELF-EMPLOYMENT/RENTAL INCOME WORKSHEET

**Not everyone is required to complete this section. Read page 5 of the instructions to see if you need to fill in this information.**

1 Check one: ❑ Self-employment income ❑ Rental income

| 2 Business name | | 3 UBI number |
|---|---|---|
| 4 Business address | City State ZIP Code | |
| 5 Type of business | | 6 Taxpayer I.D. or social security number |

| 7 Indicate the months you are reporting on this form: MO / YR – MO / YR | **COLUMN I** Total for most recent 30 days or full calendar month (must be completed for Basic Health *Plus* or Maternity Benefits Program) | **COLUMN II** Total for period you are reporting | **COLUMN III** Average per month |
|---|---|---|---|
| **INCOME** | | | **A** |
| 8 Gross receipts, sales, or rental income | $ | $ | $ |
| **EXPENSES** | | | |
| 9 Merchandise and materials | $ | $ | $ |
| 10 Gross wages paid to employees | $ | $ | $ |
| 11 Employer's payroll-related taxes | $ | $ | $ |
| 12 Advertising/other promotional expenses | $ | $ | $ |
| 13 Car and truck expenses | $ | $ | $ |
| 14 Commissions/management fees | $ | $ | $ |
| 15 Depreciation | $ | $ | $ |
| 16 Insurance | $ | $ | $ |
| 17 Interest – mortgage | $ | $ | $ |
| 18 Interest – other | $ | $ | $ |
| 19 Legal and professional services | $ | $ | $ |
| 20 Rent or lease – vehicles, machinery, or equipment | $ | $ | $ |
| 21 Rent or lease – other business property | $ | $ | $ |
| 22 Repairs and maintenance | $ | $ | $ |
| 23 Supplies | $ | $ | $ |
| 24 Taxes | $ | $ | $ |
| 25 Travel | $ | $ | $ |
| 26 Meals and entertainment | $ | $ | $ |
| 27 Utilities | $ | $ | $ |
| 28 Other expenses | $ | $ | $ |

| | |
|---|---|
| 29 **Total average monthly expenses** *Add expense totals from lines 9 through 28 in column III, and enter in B.* | — $ **B** |
| 30 **Average monthly self-employment profit (or loss)** *Subtract B from A, and record in C.* | $ **C** |
| 31 **Your share of profit (or loss)** Form of business: ❑ Sole proprietorship ❑ Partnership ❑ S-Corporation | Percentage of business you own % **D** |
| 32 Your share of average monthly self-employment/rental profit (or loss) *Multiply C by D and record here and on the Monthly Income Worksheet under "self-employment or rental profit or loss."* | $ |

# Monthly Income Worksheet Instructions

Fill out this section to report all gross family income, from all sources, before taxes. Gross family income includes all income received by you and any listed dependents, regardless of whether they're enrolled in Basic Health.

## General Instructions – Monthly Income Worksheet

For each line, show all your household's gross income received during the last 30 consecutive days or complete calendar month and fill in the name of the person who received that income. Enter the actual dollar amount (rounded to the nearest dollar), or "0" on each line.

If you or a dependent received several months' income during a single month, you may divide that income by the number of months for which the income was received. Example: You receive a $5,000 check from the Social Security Administration in October to cover your disability benefits for the months of June through October (5 months). Your monthly income from that source is $1,000 ($5,000 ÷ 5 = $1,000 per month).

Attach the documentation listed under the "Send a copy of:" column. Do not send original documents; they cannot be returned to you. All income documentation must show the date the income was received, the period for which it was earned, and the recipient's name and/or social security number. If you cannot obtain the required income documentation, send a signed, dated statement that includes the name of the person paid, the payment dates, the income source, and the payment amount before taxes or other deductions.

In addition to the documentation listed under the "Send a copy of:" column, attach a signed copy of your most recently filed federal income tax return (IRS Form 1040 and all attachments you filed with it). Whether you filed by mail or electronically, you must have signed the IRS form (your tax preparer's signature is not sufficient). If you didn't have to file or don't have a copy of your tax return for the most recent year, attach a transcript of your account or verification of nonfiling status. You can request these from the IRS by calling 1-800-829-1040 or by taking form 4506 to your local IRS office.

## Line-by-Line Instructions – Monthly Income Worksheet

**Income Averaging ("Check here if you want...")**

If your income changes enough from month to month to change your premium (generally, about $200 a month), you may want to check this box to request that your last three months' income be averaged. If you are applying for Basic Health *Plus* or the Maternity Benefits Program, DSHS will determine eligibility using income documentation for the most recent month only. If your income is averaged, your premium will not change for six months unless all Basic Health premiums change or your individual circumstances change (for example, you lose your job or your family size changes).

**Wages, salary, commissions, tips**

Fill in the amount for each adult family member. Do not include earned income for children.

**Self-employment or rental profit or loss**

Fill in the net profit or loss from self-employment or rental income. Use the amount shown on your federal income tax return, unless you are completing the *Self-Employment/Rental Income Worksheet* (see instructions for that section to find out if you need to complete it). If you complete the *Self-Employment/Rental Income Worksheet*, transfer the amount from line 32 of that section to the second line of this worksheet. Be sure to attach a signed copy of your IRS Form 1040 for the most recent year, including all schedules you filed, unless you weren't required to file. Fill in your Unified Business Identifier (UBI) number, from your Washington Master License.

**Unemployment compensation**

If you recently lost your job and received unemployment compensation, indicate the amount actually received within the most recent 30 days or calendar month. If this will not accurately reflect your income, send updated income documentation after you are enrolled.

**L&I (workers' compensation)**

Fill in the monthly amount you were awarded, before any deductions.

**Child support, family support, alimony**

Do not include payments from the Department of Social and Health Services (DSHS) adoption support program.

**Social security or supplemental security income (SSI)**

Fill in the monthly amount you were awarded, before any deductions.

**Public assistance (includes DSHS grants)**

This includes any financial assistance you receive from DSHS or other public assistance, other than adoption support.

**Retirement income or pension**

If you are reporting an IRA distribution, only show the amount of interest received.

**Other**
The table on the right shows the most common income sources that may be included here and the documentation to send for each of them.

**Subtotal**
Add all the figures in the column.

**Work-related dependent care expenses**
Fill in the total you paid to care for children 12 or younger or for a disabled adult dependent. This is also for the last 30 days or most recent calendar month (limited to $650 a month per dependent for work-related child care). For a disabled adult dependent, be sure to include proof of legal guardianship.

**Total gross monthly income**
Subtract work-related dependent care expenses from total and fill in that amount here.

| "Other" Income | Send a copy of (do not send original documents) |
|---|---|
| Income from an adult foster home | ◗ Your adult foster home license;<br>◗ Your most recently filed federal tax return (IRS Form 1040) and all applicable schedules; *and*<br>◗ Social Services Payment System (SSPS) Invoice Voucher.<br>(If you were not required to file a federal income tax form, send the *Self-Employment/ Rental Income Worksheet* completed with your income and expenses for the most recent year.) |
| Personal care worker wages | Social Service Payment System (SSPS) Service Invoice Voucher. |
| Stipends or work study | ◗ Pay stubs; or<br>◗ The award letter you received that states what you were paid and for how long. |
| Annuities | The monthly or quarterly statement from the institution that pays you. |
| Dividend income | Your statement from the bank or investment firm showing the amount of dividends for the most recent quarter or month. |
| Estates | Court documents. |
| Gambling or lottery winnings | Checks. |
| Insurance (such as life or long-term disability insurance) | The award letter or court documents showing the schedule of payments. |
| Interest income | Your statement from the bank or investment firm showing the amount of interest for the most recent quarter or month. |
| Military family allotments | Your Leave and Earning Statement (LES). |
| Royalties | ◗ Checks; or<br>◗ Contract showing the amount you are paid. |
| Strike benefits | ◗ Check stub showing dates paid and the gross amount paid; or<br>◗ Signed, dated statement from your union showing the amount paid, before any deductions. |
| Trusts | Legal trust documents. |
| Veteran's benefits | Award letter showing your current gross monthly benefits. |
| Income you cannot otherwise document | Signed and dated statement that includes your name, the date you were paid, the amount you were paid (before any deductions), and the name of the company or person who paid you. |

# Self-Employment/ Rental Income Worksheet Instructions

Complete this worksheet only if you had self-employment or rental income and:

- You are applying for Basic Health *Plus* or the Maternity Benefits Program for a family member (DSHS requires the information in column I for the most recent full calendar month);
- You were not required to file a federal income tax return; or
- You are reporting less than 12 months of income and expenses (see second paragraph under "General Instructions," below).

Otherwise, you do not need to fill out this worksheet; we will use your IRS Form 1040 and schedules to document your self-employment or rental income. Be sure to include copies of all the schedules you filed, especially schedules A - E, F, K1, and 8582 if they apply to you. Because your current profit (or loss) may have changed since the amount reported on your IRS Form 1040, you may send updated income and expense documentation (such as quarterly tax statements or monthly year-to-date profit/loss statements).

## General Instructions – Self-Employment/Rental Income Worksheet

For each line and column, fill in the appropriate dollar amount or "0."

Twelve months of income and expense history are required to determine average monthly profit (or loss). If you have owned the business or rental property for a shorter time, attach a written statement of how long you've owned the business or rental property. Then fill in current monthly income and expenses for the actual number of months you are reporting on this worksheet.

Income history from the *previous* tax year must be based on your IRS Form 1040 (if filing was required) or on historical monthly income and expense documentation.

Income history for the *current* tax year must be based on current income and expense documentation.

All expenses must be related to your business or your rental property. Other expenditures cannot be deducted from your gross family income as expenses.

### Column I

Fill in the total for the most recent full calendar month. This is necessary only if you are applying for Basic Health *Plus* or the Maternity Benefits Program for a family member.

### Column II

Fill in the total for the number of months you are reporting for the income and expense categories listed.

### Column III

Divide the total from column II by the number of months you are reporting to get the average monthly income or expense. Fill in the average.

## Line-by-Line Instructions – Self-Employment/Rental Income Worksheet

### Line 1

Check the box next to the type of income you're reporting. To report income for more than one type of business or rental, please use separate forms.

### Line 2

Write in your name or the name of your business.

### Line 3

Fill in your Unified Business Identifier (UBI) number, assigned by the Washington State License Service.

### Line 4

Fill in the address of your business. If your business is operated from your home, list your residential address.

### Line 5

Include a brief description of the type of business (like gas station, day care, etc.).

### Line 6

Fill in your federal taxpayer I.D. number. This is generally your social security number, unless your business is a partnership or a corporation.

### Line 7

Fill in the actual months for which you are reporting income and expenses.

### Line 8

Fill in the gross income receipts or sales for your business or rental income before any deductions.

### Line 9

Fill in the cost of goods sold, including the purchase price of raw materials, shipping, and storage.

### Line 10

*Do not* include payments to yourself, your spouse, or partner(s).

### Line 11

Include OASI (social security), Medicare, L&I (workers' compensation), and UI (unemployment insurance) taxes and charges.

### Line 12

Fill in your total business or rental advertising or other promotional expenses.

### Line 13

Fill in your total car or truck expenses for business-related travel. You may use the actual expense if you have proof that you spent that amount, or the standard mileage rate (32.5 cents per mile for 2000).

### Line 14

Fill in your total business or rental commissions, or management fees paid to others.

### Line 15

Fill in your annual business or rental depreciation/amortization amount. If you were not required to file an IRS Form

1040, estimate the number of years the equipment/building will be useful. Divide the purchase price by this number of years to determine annual depreciation.

**Line 16**
Fill in only the costs of insurance directly related to your business or rental activity, such as liability and property insurance. Do not include vehicle insurance costs separately if you used the standard mileage allowance for car and truck expenses (see line 13).

**Line 17**
Fill in the interest paid on real property mortgages used for your business. *Do not* include amounts paid as repayment of principal. If you use only part of your home (or other property) for business, you must determine the "business percentage" of these expenses. Generally, the business percentage for mortgage interest is the same as the percentage of the property used for business (see line 21).

**Line 18**
Fill in the interest paid on business-related loans *other than* mortgages. *Do not* include amounts paid as repayment of principal.

**Line 19**
Fill in your total business- or rental-related legal and professional expenses, such as attorney, accountant, and appraiser fees.

**Line 20**
Fill in your business- or rental-related expenses for rent or lease of vehicles, machinery, or equipment.

**Line 21**
Fill in the business- or rental-related expenses for rent or lease of other business property. If the entire property is not used exclusively for business, measure the area of the property in square feet and calculate this by dividing the area of the property used for business by the total area of the property, including the basement. Example: Your property measures 1,200 square feet. You use one room that measures 240 square feet for business. Therefore, you use one-fifth (240 ÷ 1,200), or 20%, of the total area for business.

**Line 22**
Fill in the business- or rental-related expenses for routine repair and maintenance of your business, equipment, vehicle(s), or rental property. *Do not* include payments for your own labor, or car- and truck-related expenses from line 13.

**Line 23**
Fill in your business- or rental-related expenses for supplies, such as office supplies, postage, shipping, and handling for your business.

**Line 24**
Fill in your business- or rental-related *non*payroll taxes, such as property taxes, business and occupational taxes, and business-related license fees. You may list half of the self-employment tax you paid.

**Line 25**
Fill in business-related travel expenses, which are ordinary and necessary expenses incurred while traveling for your business or profession. *Do not* include expenses listed in line 13.

**Line 26**
Fill in your business-related expenses for meals and entertainment.

**Line 27**
Fill in business-related expenses for utilities such as heat, lights, power, and telephone service. List only utility expenses used to support your business. If you use only part of your home (or other property) for business, determine the business percentage of these expenses, generally the same as the percentage of property used for business (see line 21). Example: your electric bill is $400 for lighting, cooking, laundry, and television. Only the lighting bill is used for business. If $250 of your electric bill is for lighting and you use 10% of your property for business, then $25 is considered a business-related expense.

**Line 28**
Fill in other related business expenses that you will file with your tax return and describe them briefly.

## Calculations

**Line 29**
Add the figures in column III, lines 9 through 28, to determine your total average monthly expenses. Write this amount in box B.

**Line 30**
Subtract the amount in box B from the amount in box A (at the top of column III) to determine your average monthly self-employment profit (or loss) amount. Write this amount in box C.

**Line 31**
Check the box next to the appropriate form of business. Determine the percentage of business that you own and write that percentage in box D. If you and your spouse are both partners in the business, this would be the sum of your ownership percentages. Use 100% for a sole proprietorship.

**Line 32**
Multiply the amount in box C by the percentage in box D to determine your share of the average monthly self-employment/rental net profit (or loss). Transfer this amount to the Monthly Income Worksheet, in the box for "Self-employment or rental profit or loss".)

# Keep *Hot Policy Pages* Here

*Hot Policy Pages* are important updates to this Member Handbook and are one way Basic Health provides you with official notice of program changes; you will receive them periodically, usually with your monthly billing statement. Keep these updates, along with this *Member Handbook* and other information you receive from Basic Health handy, so that you have the information you need to make the most of your Basic Health coverage.

For information on providers available to you and approval of specific services, call your health plan.